STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E247	A. BUILDING 00 B. WING	04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL HERMITAGE	501 N 17TH AVE BEECH GROVE, IN 46107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: April 23, 24, 25, 26, and 27, 2012 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, MS Barbara Hughes, RN (April 25th and 26th) Census Bed Type: NF: 48 Residential: 33 Total: 81 Census Payor Type: Medicaid: 28 Other: 53 Total: 81 Residential Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on May 2, 2012 by Bev Faulkner, RN			

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to revise a resident's fall care plan after a quarterly assessment to accurately reflect the resident's status for 1 of 3 residents reviewed in the sample of 3 who met the criteria for falls. (Resident #12) Findings include: The clinical record for Resident #12 was reviewed on 4/25/12 at 11:00 a.m. The diagnoses for Resident #12	F0280	Care plan for resident #12 was reviewed and fall care plan was updated to reflect resident's current assessment- identified condition and needs on 4/27/12, including goal change tha resident be free of injury associated with falls in next 90 days. Direct care staff was informed by written care plan summary located in hall ADL log. MDS/CP RN will review care plans of assessment-identified residents with fall risk scores of 10 or greater and those with falls within the past 180 days for accuracy and relevance and update as needed by 5/27/12. MDS/CP RN and unit manager RN will review post-fall	05/27/2012

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	included, but were not limited to: bowel perforation, degenerative joint disease, hypertension, constipation, hypoglycemia, anemia, and osteoarthritis. The 4/3/12 quarterly MDS (Minimum Data Set) assessment indicated Resident #12 was at risk for falls, had 2 or more falls with no injury, and 0 falls with injury since the last assessment on 1/10/12. The clinical record indicated Resident #12 had 2 falls during the quarter between the 1/10/12 MDS assessment and the 4/3/12 MDS assessment. One fall was on 1/29/12, and the other fall was on 2/22/12. The most recent falls care plan was requested from and provided by RN #3 on 4/25/12 at 2:00 p.m. The care plan indicated a review date of 1/10/12 and a "next review" date of 4/5/12. The care plan indicated the problem was Resident #12 had fallen 6 times during the quarter. The problem also referenced a fall on 11/26/11 in which the resident sustained a 1 cm laceration over his right eye. The goal was for the resident to be free of falls.		investigation report and add identified intervention to fall care plan and staff care plan summary by 5/27/12. MDS/CP RN will utilize post fall investigation reports and 24 hour reports to formulate accurate fall care plans and will communicate changes to staff by revised written care plan summaries in hall ADL logs. A fall investigation report is completed after each fall (See attached fall investigation report). This is forwarded to the MDS/CP RN who then updates the care plan, prints a copy of the same (see attached) and places it in the staff ADL log. (The ADL log contains elimination tracking forms, CNA ADL charting, restorative care flowsheets, full and quarterly assessment care plans all revised updated careplans and social service pre-admit summaries). Pertinent staff are notivied by the MDS/CP RN via Interdepartmental Communication sheets (see attached) of updated care plans in ADL log. System will be reviewed and evaluated in quarterly QA committee meetings for one year. A flow sheet for fall care plan update distribution (see attached) will be used by the MDS/CP RN to monitor the efficacy of the system. Corrections described above will be completed by 5/27/12	

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	During interview with RN #3 on 4/27/12 at 10:50 a.m., she indicated the part in Resident #12's fall care plan about him falling 6 times in the quarter was not correct. She indicated the care plan goal should now be to have reduced injury from falls and not to be free of falls as the care plan indicated. She indicated she usually updated the care plan between the assessment reference date and the care plan meeting date. She stated, "I think I forgot to update the care plan." 3.1-35(d)(2)(B)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure precautions were in place to prevent a fall and further potential falls for 1 of 3 residents reviewed in a sample of 3, who met the criteria for falls. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 4/25/12 at 11:30 a.m. The diagnoses for Resident #21 included, but were not limited to: bilateral total knee replacement, macular degeneration, senile dementia-Alzheimer's type with delusions and agitation. In a record review of the fall investigation from a fall on 4/8/12 at 1 a.m., received from the Unit Manager on 4/26/12 at 11:00 a.m., the report indicated that a new intervention was to be implemented after the fall. The intervention was to put on non-skid	F0323	Care plan for resident #21 was reviewed and fall care plan was updated to reflect resident's current assessment-identified condition and needs on 4/27/12, including intervention for staff to check walker placement in room frequently as resident consistently places it in location not within reach and is cognitively unable to remember to do so. Staff will place non-skid socks on resident each HS and track same on treatment administration record. Direcvt care staff was informed by written care plan summary located in hall ADL log. MDS/CP RN will review care plans of assessment-identified residents with fall risk scores of 10 or greater and those with falls within past 180 days for accuracy and relevance and update as needed by 5/27/12. MDS/CP RN and unit manager RN will review post-fall investigation report and add identified intervention to fall care plan and staff care plan summary by 5/27/12. MDS/CP RN will utilize post fall investigation reports and 24 hour reports to formulate accurate fall care plans and communicate changes to staff by revised	05/27/2012

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	socks when assisted to bed at night. A fall care plan, dated 4/17/12, one intervention was, "The staff will keep Fr's [Father's] walker within easy reach and remind him often to use it when ambulating. The staff will make sure Father has his shoes on or non-skid socks on." In a fall investigation, from a fall on 4/18/12 at 9:30 p.m., received from the Unit Manager on 4/25/12 at 11:40 a.m., the report indicated that the Resident #21 went to bed and had on regular socks. On 4/26/12 at 11:50 a.m., in an interview with RN #1, she indicated Resident #21 wasn't wearing non-skid socks when he fell on 4/18/12 at 9:30 p.m. She also indicated that she wasn't sure if the non-skid socks were put on at bedtime or if he took them off. During an observation, on 4/25/12 at 2:30 p.m., Resident #21 was laying in bed, with his walker near the opposite wall and not within easy reach. On 4/26/12 at 1:45 p.m., Resident #21 was observed lying in bed, with his walker near the opposite wall and not within easy reach.		written care plan summaries in hall ADL logs. System will be reviewed and evaluated in quarterly QA committee meetings for one year. MDS/CP RN will utilize post fall investigation reports and 24 hour reports to formulate accurate fall care plans and will communicate changes to staff by revised written care plan summaries in hall ADL logs. A fall investigation report is completed after each fall (See attached fall investigation report). This is forwarded to the MDS/CP RN who then updates the care plan, prints a copy of the same (see attached) and places it in the staff ADL log. (The ADL log contains elimination tracking forms, CNA ADL charting, restorative care flowsheets, full and quarterly assessment care plans all revised updated careplans and social service pre-admit summaries). Pertinent staff are notified by the MDS/CP RN via Interdepartmental Communication sheets (see attached) of updated care plans in ADL log. System will be reviewed and evaluated in quarterly QA committee meetings for one year. A flow sheet for fall care plan update distribution (see attached) will be used by the MDS/CP RN to monitor the efficacy of the system. All corrections described above will be completed by 5/27/12.	

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	Resident #21 was observed lying in bed, on 4/26/12 at 2:55 p.m., with his walker near the opposite wall, as the same spot as the previous observations and not within easy reach. During an interview with LPN #2, on 4/26/12 at 2:57 p.m., she indicated that Resident #21 should have his walker near him and within easy reach. When queried why the walker hasn't been near the resident during the observations of the resident, LPN #2 indicated that she didn't know and would go move the walker near the resident. On 4/27/12 at 1:20 p.m., Resident #21 was observed lying in bed, with his walker near the opposite wall and not within easy reach. 3.1-45(a)(2)			

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